MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12442

CERTIFICATE OF DEATH

Reg. Dist. No. 12419

1. PLACE OF DEATH
a. COUNTY: Carroll Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster Md.
c. LENGTH OF STAY IN 1b: 3yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ----------

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster Md.
d. STREET ADDRESS: 622 Old Baltimore Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Jacob Last Basler

4. DATE OF DEATH: Month Nov. Day 10 Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 20, 1867

9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Basler

14. MOTHER'S MAIDEN NAME: Maria Shorb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: none

INFORMANT: Mrs. Ethel Schaeffer Address: 622 Old Balto Blvd. Westminster Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, Bronchial
DUE TO (b): Carcinoma, Myocardial (acute)
DUE TO (c): Nephritis (chr)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

153.2

INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ____ a. m. p. m. Month ____ Day ____ Year 19____

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1930, to 11-10-, 1960 that I last saw the deceased alive on 11-9-60, 19____, and that death occurred at 10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. C. Jennette M.D. ADDRESS (Street, city or town, state): Westminster, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): Wm. C. Jennette MD Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/13/60

22c. NAME OF CEMETERY OR CREMATORY: Leisters Cemetery

22d. LOCATION (City, town, or county) (State): near Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Saffell ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: NOV 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kuhns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Item 20 Film 276 12-13-60

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12446 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12420

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): R1 - Hampstead
c. LENGTH OF STAY IN 1b: 18 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Snydersburg.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hampstead Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VERLIN Middle DALLAS Last BENGE
4. DATE OF DEATH: Month May Day 30 Year 1960
5. SEX: M.
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-16-1923
9. AGE (In years last birthday): 37 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder
10b. KIND OF BUSINESS OR INDUSTRY: Balto Steel Co
11. BIRTHPLACE (State or foreign country): N. Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Willie Benge
14. MOTHER'S MAIDEN NAME: Artie Greene
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes, World War #2
16. SOCIAL SECURITY NO.: 220-18-3345
17. INFORMANT: Address: Mrs Verlin Benge - Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gunshot wound of chest — INTERVAL BETWEEN ONSET AND DEATH: min
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
9 19 9
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Accidentally shot with 22 revolver
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year -- 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --
20f. (City or town) (County) (State): - Carr.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T Marsh M.D.
EXAMINER'S NAME (Type): JAMES T MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-30-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-3-1960
22c. NAME OF CEMETERY OR CREMATORY: Snydersburg
22d. LOCATION (City, town, or country) (State): Carroll Co Md

23. FUNERAL DIRECTOR: Edw A Tipton ADDRESS: Hampstead Md
24a. REC'D BY REGISTRAR: DATE DEC 5 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kuhn

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12447 12421

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (8)
1SM 9/59

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester RD#1
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Melrose

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Manchester, RD#1
d. STREET ADDRESS: Melrose
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First JACOB Middle HERMAN Last BISHOP

4. **DATE OF DEATH**: Month Nov. Day 17 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 29, 1908

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): truck driver

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Fairfield, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Amos Bishop

14. MOTHER'S MAIDEN NAME: Annie Glacken

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-28-7027

17. **INFORMANT** Address: Mrs. Jacob H. Bishop, Manchester Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adenocarcinoma Sigmoid Colon — INTERVAL BETWEEN ONSET AND DEATH: 3 Mon.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Metastases to Brain & Lung

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 10-14 1960, to 11-17 1960, that (I) (we) last saw the deceased alive on 11-7 1960, and that death occurred at 8:30 A.M., P.M., from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D. M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): W H Foard M.D.

22d. ADDRESS: Manchester, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/19/60

23c. NAME OF CEMETERY OR CREMATORY: Dover Church Cemetery

23d. LOCATION (City, town, or county) (State): Worthington Valley, Balto. Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. ADDRESS: Westminster, Md

25a. REC'D BY REGISTRAR DATE: NOV 21 '60

25b. REGISTRAR'S SIGNATURE: Arthur B. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12441 Item 1 rim 6-275 11-28-60 et

CERTIFICATE OF DEATH

12422

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Taneytown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Private home	d. STREET ADDRESS: 231 E. Baltimore Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Nettie	May	Boyd	November	19,	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		June 5, 1882	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nelson Boyd	Lavina Babylon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none	Mr. Charles T. Humbert, Taneytown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Chronic Nephritis	2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arterio-sclerosis Generalized	6 yrs
DUE TO (c)	Senility	6 yrs

4467

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Decubitus Ulcers

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1957, to Nov. 1960, that (I) (we) last saw the deceased alive on Nov. 17 1960, and that death occurred at 4 A.M., from the causes and on the date stated above.

22a. SIGNATURE		22b. DATE SIGNED
E. Dudley Thompson M.D.	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	11/19/60
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	11-22-60	Grace Reformed Cemetery	Laneytown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Norwood C. Fuss C. O. Fuss & Son	Taneytown, Maryland	NOV 23 '60	Thos L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12448

CERTIFICATE OF DEATH

12423

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 3 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upnco Rural
d. STREET ADDRESS 03X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Wilson Middle Last Cofield

4. DATE OF DEATH Month 11 Day 15 Year 1960

5. SEX Male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH May 29-1872
9. AGE (In years last birthday) 88 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Blacksmith
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andrew Cofield
14. MOTHER'S MAIDEN NAME Sally Winner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
17. INFORMANT Address Mrs Emma Wilhelm - Balto Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Hemorrhage Ca of Stomach — Interval between onset and death: Sudden

151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Generalized Carcinoma — one month.
DUE TO (c) Terminal Ca. of Stomach. — 6 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
C.V.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 15, 1960, to Nov 18, 1960, that I last saw the deceased alive on Nov 15, 1960, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Sani Okutman M.D. ADDRESS (Street, city, or town, state) 37 Central Ave. DATE SIGNED 11.18.60

PHYSICIAN'S NAME (Type) Sani Okutman Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-21-1960
22c. NAME OF CEMETERY OR CREMATORY Mt Zion
22d. LOCATION (City, town, or county) Balto Co (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Edw A Tipton ADDRESS Hampstead Md
24a. REC'D BY REGISTRAR DATE NOV 28 '60
24b. REGISTRAR'S SIGNATURE Clinton L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12449

12424

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 38yrs.6mos.7days

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUT ON: Springfield State Hospital

d STREET ADDRESS: 2738 E.Preston St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Cuilla

4. DATE OF DEATH: Month: November — Day: 6, — Year: 1960

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1881

9 AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: -

11 BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? Unknown

13 FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Peptic ulcer

5420

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Months

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, paranoid type.

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from March 7, 1960, to Nov. 6, 1960, that (I) (we) last saw the deceased alive on November 6 1960, and that death occurred at 10:30 PM from the causes and on the date stated above

22a SIGNATURE: Agustin del Campo M D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11/7/60

22c PHYS CIAN S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Nov-10-1960

23c NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery

23d LOCAT ON (City, town, or county) (State): Belair Rd Balto 6 - Md

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph Fiasco, Inc 712 E. North ave.

25a REC'D BY REGISTRAR DATE NOV 9 '60

25b REGISTRAR'S SIGNATURE: Clifford S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12450

CERTIFICATE OF DEATH

12425

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 14yr 9mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 24, Maryland
d. STREET ADDRESS: 2307 E. Fairmount Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leon — Middle: Lion — Last: Darvin (Correction: ~~Julius Leon Darvin Berano~~)

4. DATE OF DEATH: Month: 11 — Day: 20 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-9-91

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR / UNDER 24 HRS: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Junk Dealer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Meyer Lipstein

14. MOTHER'S MAIDEN NAME: Lea Nachman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield State Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH: years

181.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Manic Depressive Reaction, Manic Type

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-22-59 to 11-20 1960 that (I) (we) last saw the deceased alive on 11-20 1960, and that death occurred at 7A M, from the causes and on the date stated above

22a. SIGNATURE: Agustin del Campo. M D

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11/20/60

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-21-60

23c. NAME OF CEMETERY OR CREMATORY: Beth Isaac

23d. LOCATION (City, town, or county) (State): Balto Md

24. FUNERAL DIRECTOR'S SIGNATURE: Jack Lewis Inc — ADDRESS: 2100 Eutaw Pl

25a. REC'D BY REGISTRAR — DATE: NOV 21 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12451

CERTIFICATE OF DEATH

12426

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taneytown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Enroute to Hospital on Route #194

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Taneytown
d. STREET ADDRESS: Frederick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Estella; Middle: Laura; Last: Devilbiss

4. DATE OF DEATH: Month: November; Day: 28; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 30, 1878

9. AGE (In years last birthday): 82 yrs

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isiah Reifsnider

14. MOTHER'S MAIDEN NAME: Mary Rebecca Lippy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-34-1510

17. INFORMANT (Address): Mr. John Devilbiss, Taneytown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion 420.7	1 hr.
DUE TO (b)	Coronary Sclerosis	2 yrs
DUE TO (c)	Generalized Arteriosclerosis	4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Varicose Ulcers Legs

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from Sept, 1958, to Nov, 1960, that (I) (~~me~~) last saw the deceased alive on Nov 28 1960 and that death occurred at 1P M, from the causes and on the date stated above.

22a. SIGNATURE: E. Ambler Thompson M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11/28/60

22c. PHYSICIAN'S NAME (Type): E. Ambler Thompson

22d. ADDRESS: Taneytown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 30, 1960

23c. NAME OF CEMETERY OR CREMATORY: Reformed Cemetery

23d. LOCATION (City, town, or county) (State): Taneytown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: C.O. Fuse & Son

ADDRESS: Taneytown, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 1 '60

25b. REGISTRAR'S SIGNATURE: Calvin S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12427

12452

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Westminster
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- New Windsor
d. STREET ADDRESS: R. D. 2 10X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PETER Middle THOMAS Last DUDDERAR

4. DATE OF DEATH: November 9, 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 19, 1887

9. AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.A.

13. FATHER'S NAME: Warren E. Dudderar

14. MOTHER'S MAIDEN NAME: Maggie Barnes

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 212-32-4132

17. INFORMANT: Ralph T. Barnes, Address: Same as # 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Min.
DUE TO
(b): Coronary Insufficiency — Years.
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11-30, 1957 to Nov. 9, 1960, that I last saw the deceased alive on Sept 25, 1960, and that death occurred at 9 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T Marsh M.D.
ADDRESS (Street, city or town, state): 105 E Main St - Westminster Md
DATE SIGNED: 11/10/60

PHYSICIAN'S NAME (Type): JAMES T MARSH

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Nov. 11, 1960
22c. NAME OF CEMETERY OR CREMATORY: Linganore Cemetery
22d LOCATION (City, town, or county) (State): Frederick Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland

24a. REC'D BY REGISTRAR DATE: NOV 14 '60

24b. REGISTRAR'S SIGNATURE: C Flint S Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12440

CERTIFICATE OF DEATH

12428 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
c. LENGTH OF STAY IN 1b 12 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Ave. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
d. STREET ADDRESS Park Ave. Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First FRED Middle LINEAUS Last ENGLE

4. DATE OF DEATH Month NOV. Day 24 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec 30, 1909
9. AGE (In years last birthday) 50 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) supervisor of education (High Schools)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Salisbury, Pa.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Irvin J. Engle
14. MOTHER'S MAIDEN NAME Cora Newman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 219-18-5583
17. INFORMANT Address Mrs. Fred L. Engle, same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) — DUE TO (c) —
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 19[illegible], to Nov 24, 19[illegible], that I last saw the deceased alive on Nov 15, 19[illegible], and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE W H Foard M.D. ADDRESS (Street, city or town, state) Manchester, Md DATE SIGNED 11-24-60

PHYSICIAN'S NAME (Type) W. H. Foard, M.D. Manchester, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/26/60
22c. NAME OF CEMETERY OR CREMATORY Manchester Cemetery
22d. LOCATION (City, town, or county) (State) Manchester, Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers Jr. ADDRESS Westminster, Md
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12443

CERTIFICATE OF DEATH

Reg. Dist. No. 12429

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 10 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 13 JOHN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle HOWARD — Last ESWORTHY

4. DATE OF DEATH: Month NOV. — Day 19 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 2, 1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LANDSCAPING
10b. KIND OF BUSINESS OR INDUSTRY: LANDSCAPING
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES (NMI) ESWORTHY
14. MOTHER'S MAIDEN NAME: RACHAEL S. DUVALL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 220-26-5677
INFORMANT: HERBERT ESWORTHY — Address: RT #1 NEW WINDSOR, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CELEBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
332.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN. 25, 1955 to NOV. 19, 1960 that I last saw the deceased alive on NOV. 19, 1960, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William L. Stewart, M.D. — ADDRESS (Street, city or town, state): 19 RIDGE RD, — DATE SIGNED: 11/19/60

PHYSICIAN'S NAME (Type): WILLIAM L. STEWART — WESTMINSTER, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-22-1960
22c NAME OF CEMETERY OR CREMATORY: Locust Grove Brethren
22d LOCATION (City, town, or county) (State): Frederick CO., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, — ADDRESS: Winfield, Md.
24a. REC'D BY REGISTRAR DATE NOV 22 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24
ed by the hospital or attending physician.
IRECTOR: After this certificate has been signed by the attending physician and completely filled

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12453

12430

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville

c. LENGTH OF STAY IN 1b 7mo. 8days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital

d. STREET ADDRESS 1629 Belt Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Harry Middle George Last Jr. Findling

4. DATE OF DEATH Month 11 Day 2 Year 1960

5. SEX male

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH 8-23-18

9. AGE (In years last birthday) 42 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry G. Findling, Sr.

14. MOTHER'S MAIDEN NAME Mary Ann Spieker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknwon (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-22-5540

17. INFORMANT Address Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Coronary Artery Spasms

DUE TO (c) Bronchopneumonia

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sociopathic personality disturbance, Alcoholism (addiction)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 24 1960 to Nov. 2 1960, that (I) (we) last saw the deceased alive on Nov. 2 1960, and that death occurred at 7:40 A. M., from the causes and on the date stated above.

22a. SIGNATURE Yasuo Takahashi M.D.

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED 11-2-60

22c. PHYSICIAN'S NAME (Type) Yasuo Takahashi

22d ADDRESS Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) B

23b. DATE THEREOF 11 5 60

23c. NAME OF CEMETERY OR CREMATORY Cathedral

23d. LOCATION (City, town, or county) Baltimore (State)

24. FUNERAL DIRECTOR'S SIGNATURE Henry T. Howes

ADDRESS 130 E. Fort Ave

25a. REC'D BY REGISTRAR DATE NOV 4 60

25b. REGISTRAR'S SIGNATURE Chas. L. Howes

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12454 12431

1 PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE-(RURAL)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GOLDEN AGE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RUXTON 4
d. STREET ADDRESS: MAPLE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSIE Middle COALE Last FISHPAW

4. DATE OF DEATH: Month NOVEMBER Day 3, Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 2, 1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES COALE
14. MOTHER'S MAIDEN NAME: MYRA LEE

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: FAMILY RECORDS Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic
DUE TO (b): Coronary thrombosis
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs. 1 mo. 8 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o m. p m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 26 1960 to Nov 3d 19 60, that (I) (we) last saw the deceased alive on Nov 3 1960, and that death occurred at 3:10 P.M., from the causes and on the date stated above

22a. SIGNATURE: Harrell F. Mastin, M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED
22c. PHYS. CIAN'S NAME (Type): HARRELL F MASTIN
22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): Nov 7, 1960
23b DATE THEREOF: Nov. 7, 1960
23c. NAME OF CEMETERY OR CREMATORY: PROSPECT HILL CEM.
23d LOCATION (City, town, or county) (State): TOWSON, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John Burns Sons
ADDRESS: Towson, Md.
25a REC'D BY REGISTRAR DATE NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12455

CERTIFICATE OF DEATH

12432
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg R.D.1
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Old Westminster Road

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg R.D.1
d. STREET ADDRESS: Old Westminster Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Griselda — Last: Frazier

4. DATE OF DEATH: Month: Nov. — Day: 23 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 3, 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George M.Frazier
14. MOTHER'S MAIDEN NAME: Mary Adelaide Lauver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: Joseph M.Frazier, Address: Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardio-Vascular Disease — years

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 13, 1951, to Nov. 22, 1960, that I last saw the deceased alive on Nov.22, 1960, and that death occurred at 1:45A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin E. Strobel M.D.
ADDRESS (Street, city or town, state): 48 Main Street, Reisterstown, Maryland
DATE SIGNED: 11-23-60
PHYSICIAN'S NAME (Type): Martin E. Strobel M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov.26,1960
22c. NAME OF CEMETERY OR CREMATORY: Finksburg Cemetery
22d. LOCATION (City, town, or county) (State): Finksburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J.E.Myers Jr., Westminster, Md. J. E. Myers Jr.
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12456 Item 2-Film 240-12-2-60 et

12433

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 29 days

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll 96
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Sykesville~~ Woodbine
d. STREET ADDRESS: Route # 1 ~~Klees Mill Rest Home, Sykesville, Md.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

3. NAME OF DECEASED (Type or print): First Walter — Middle — Last Haines
4. DATE OF DEATH: Month Nov. — Day 25 — Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-4-1890
9. AGE (In years last birthday): ~~69~~ yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown ~~Laborer~~
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Levi Haines
14. MOTHER'S MAIDEN NAME: Amanda Jenkins.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): Gastric ulcer — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome due to Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-26- 1960, to 11-25- 1960, that (I) (we) last saw the deceased alive on 11- 24- 1960, and that death occurred at 2.45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo MD
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-25-60
22c. PHYSICIAN'S NAME (Type): Agustin del Campo.M.D.
22d. ADDRESS: Springfield State Hospital Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 28, 1960
23c. NAME OF CEMETERY OR CREMATORY: Winfield Church of God
23d. LOCATION (City, town, or county) (State): Carroll Co., Maryland
24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. M. Waltz, Winfield, Maryland
25a. REC'D BY REGISTRAR — DATE: NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Hawn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12457

CERTIFICATE OF DEATH

12434

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 10mo. 22da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 11,
d. STREET ADDRESS: 818 W. 37th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: Johnson; Last: Hitchings, Sr.

4. DATE OF DEATH: Month: November; Day: 30; Year: 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 5-31-81
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician & Painter
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard R. Hitchings
14. MOTHER'S MAIDEN NAME: Elizabeth -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield State Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Arteriosclerotic cardiovascular disease	5 years
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Severe coronary artery disease	15 years
DUE TO (c)		

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS assoc. with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m.; Month; Day; Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 8 19 60 to November 30 19 60, that (I) (we) last saw the deceased alive on November 30 1960, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 11-30-60
22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/3/60
23c. NAME OF CEMETERY OR CREMATORY: Loraine Park
23d. LOCATION (City, town, or county) (State): Balto Co.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Paul E. Schenauer Jr. 3617 Chestnut Ave
25a. REC'D BY REGISTRAR DATE: DEC 6 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12458 12435

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 1y. 3m. 11d.
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brownsville
d. STREET ADDRESS: 21 X 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ ?

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Rebecca; Last: Holder

4. DATE OF DEATH: Month: 11; Day: 3; Year: 1960

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/28/68

9. AGE (In years last birthday): 91 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Henry Thompson

14. MOTHER'S MAIDEN NAME: OCTAVIA Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Springfield Hospital records — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia associated with heart failure — INTERVAL BETWEEN ONSET AND DEATH: days

450.8

DUE TO (b): Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with disturbance of Metabolism, Growth or Nutrition with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 7/22 1959, to 11/3/ 1960, that ☒ (we) last saw the deceased alive on 11/3 1960, and that death occurred at 1:15 p.m. from the causes and on the date stated above

22a. SIGNATURE: Konstantin Weber M.D.

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11/4/60

22c. PHYSICIAN'S NAME (Type): Konstantin Weber, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 6-1960

23c. NAME OF CEMETERY OR CREMATORY: Brownsville Cemetery

23d. LOCATION (City, town, or county) (State): Brownsville Washington Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast — ADDRESS: Boonsboro MD

25a. REC'D BY REGISTRAR DATE: NOV 9 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12459

12456

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore City
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville	c. LENGTH OF STAY IN 1b: 9mo. 11da.
	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 31, Maryland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 2237 W. Duncan Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
William	Michael	Menzel	11	23	19 60

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
☒ Male	White		11-15-85	75 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Factory Worker	-	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter C. Menzel	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	-	216-01-9015	Springfield State Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Asphyxia due to occlusion of both bronchi with	instant
DUE TO	aspirated food.	
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic heart disease due to coronary	years
DUE TO (c)	arteriosclerosis.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from November 4, 19 60 to November 23, 19 60 that (I) (we) last saw the deceased alive on November 23 19 60, and that death occurred at 2:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒	22b. DATE SIGNED
Agustin del Campo M.D.		11-23-60
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	22d. ADDRESS Springfield State Hospital Sykesville, Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	11/28/60	Holy Redeemer	Baltimore

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Philip Herwig Sons	2024 Oakmont Ave	NOV 28 '60	Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12460

12457

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 4 mos. 9days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield state Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 115 Record St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leonora — Middle: Cecelia — Last: MILLER
4. DATE OF DEATH: Month: November — Day: 2 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-Aug 1880
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10b KIND OF BUSINESS OR INDUSTRY: Home for the Aged
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis ~~Kaurx~~ Miller
14. MOTHER'S MAIDEN NAME: Lydia Storm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute hemorrhage due to perforation of the ~~aneurysm of the aorta into the trachea.~~ 451X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbance, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from June 23, 1960, to November 1 1960, that (I) (we) last saw the deceased alive on Nov. 1 1960, and that death occurred at 7:30 M, from the causes and on the date stated above

22a SIGNATURE: Ilse Kamm M.D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b DATE SIGNED: 11-2-60
22c PHYSICIAN'S NAME (Type): Ilse Kamm, M. D.
22d ADDRESS: Springfield State Hospital - Sykesville, MD.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11-4-60
23c NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
23d LOCATION (City, town, or county) (State): Frederick, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: M. R. Etchison & Son, Frederick, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 7 '60
25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12461

CERTIFICATE OF DEATH

12438

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 8yr.1m.1d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUT ON: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: North Mechanic Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry; Middle: William; Last: Morris

4. DATE OF DEATH: Month: November; Day: 28; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-6-1894

9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield State Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with intoxication, alcohol intoxication, psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from November 23 1960 to November 28 1960, that (I) (we) last saw the deceased alive on November 28 1960, and that death occurred at 12:15 P. M., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-28-60

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: (11-30,60)

23c. NAME OF CEMETERY OR CREMATORY: Ft. McHenry Burial Ground

23d. LOCATION (City, town, or county) (State): Baltimore Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Frank H. Harrold Sons Inc

25a. REC'D BY REGISTRAR DATE: DEC 2 '60

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12462 12439

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 MAIN Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead
d. STREET ADDRESS 3 S. MAIN Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First SUSAN Middle Alberta Last Murray
4. DATE OF DEATH Month November Day 1 Year 1960

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH NOV 5, 1875
9. AGE (In years last birthday) 85 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Cornelius Lippy
14. MOTHER'S MAIDEN NAME Amelia Keller

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO None
17. INFORMANT Mrs Helen Hoffman Address Phila Penna

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis
4424 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardio Vascular Disease
DUE TO (c) Generalized Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from March 1 1959 to NOV 1 1960 that (I) (we) last saw the deceased alive on Oct 31 1960, and that death occurred at 2:45 P.M. from the causes and on the date stated above

22a SIGNATURE Joseph E Bush M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 11-1-60
22c PHYSICIAN'S NAME (Type) Joseph E. Bush MD
22d ADDRESS HAMPSTEAD Maryland

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 11-4-60
23c NAME OF CEMETERY OR CREMATORY Hampstead
23d. LOCATION (City, town, or county) Carroll Co (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE Edw L Upton ADDRESS Hampstead Md
25a. REC'D BY REGISTRAR DATE NOV 7 '60
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12463

CERTIFICATE OF DEATH

12440

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2205 Hamilton Ave.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Virginia — Middle Daré — Last NELSON

4. DATE OF DEATH: Month 11 — Day 11 — Year 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/28/90
9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Salter
14. MOTHER'S MAIDEN NAME: Alice Cory

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Address: Springfield State Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Infected decubitus — weeks

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/24/55, 19__, to 11/11/60, 19__, that (I) (we) last saw the deceased alive on 11/11/60 19__, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Rita S. Glahn M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 11/12/60
22c. PHYSICIAN'S NAME (Type): Rita S. Glahn, M.D.
22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 11-14-60
23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
23d. LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Leonard J. Ruck 5305 Harford Rd.
25a. REC'D BY REGISTRAR DATE: NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12444

CERTIFICATE OF DEATH

12441

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b 25 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION 31 N. Colonial Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
d. STREET ADDRESS 31 N. Colonial Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CHESTER Middle ARTHUR Last NITSCH

4. DATE OF DEATH Month Nov. Day 2 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov 27 1887
9. AGE (In years last birthday) 72 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter-drug store (retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Arthur Nitsch
14. MOTHER'S MAIDEN NAME Elizabeth Chakobei

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ?
17. INFORMANT Address Mrs. Fannie B. Nitsch, Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRYTHMIA. — INTERVAL BETWEEN ONSET AND DEATH 2 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 427.1

DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. — 20 YEARS

DUE TO (c) PULMONARY EMPHYSEMA — 20 YEARS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour o. m p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from AUG 10 1957 to NOV 2 1960, that (I) (we) last saw the deceased alive on OCT 15 1960, and that death occurred at A.M. from the causes and on the date stated above

22a SIGNATURE Daniel I Welliver M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED NOV 2 1960
22c PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER
22d. ADDRESS 19 RIDGE RD WESTMINSTER MD

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 11/5/60
23c NAME OF CEMETERY OR CREMATORY St. Johns Cemetery
23d LOCATION (City, town, or county) (State) Westminster, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. E. Myers Jr. Westminster, Md.
25a REC'D BY REGISTRAR DATE NOV 4 '60
25b. REGISTRAR'S SIGNATURE Carlton E. Keefer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12464

CERTIFICATE OF DEATH

Reg. Dist. No. 12442

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg — c. LENGTH OF STAY IN 1b: 5 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cedarhurst Road	d. STREET ADDRESS: Cedarhurst Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Charles	William	Otto III	November	6	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		Nov. 9, 1954	5 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles William Otto Jr.	Thelma Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
		Charles W. Otto Jr. Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rhabdomyosarcoma of Naso-pharanx — INTERVAL BETWEEN ONSET AND DEATH: 5 months

DUE TO (b) with asphyxia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
a. m. / p. m. 19			

21. I certify that I attended the deceased from Dec. 1, 1954, to Nov. 6, 1960 that I last saw the deceased alive on Nov. 6, 1960, and that death occurred at 11 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin E. Strobel M.D. — ADDRESS (Street, city or town, state): 48 Main Street — DATE SIGNED: 11-7-60

PHYSICIAN'S NAME (Type): Martin E. Strobel, M.D. — Reisterstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Nov. 9, 1960	Finksburg Cemetery	Finksburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
J. E. Myers, Jr. Westminster, Md.	NOV 9 '60	Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12465 12443

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster
c. LENGTH OF STAY IN 1b 6 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stone Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland COUNTY Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster RD#2
d. STREET ADDRESS Stone Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: WILLIAM Middle: A. Last: ROETHER
4. DATE OF DEATH Month: NOV. Day: 28 Year: 1960
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Sept. 8 1870
9. AGE (In years last birthday) 90 yrs
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Counter Man
10b. KIND OF BUSINESS OR INDUSTRY Restaurant
11. BIRTHPLACE (State or foreign country) Near Frankfurt, Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gesler Roether
14. MOTHER'S MAIDEN NAME Not known, lived in Germany

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-16-5053A
17. INFORMANT Address: Henry J. Roether, Westminster Md. RD#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral softening — INTERVAL BETWEEN ONSET AND DEATH 1½ yrs
DUE TO (b) Generalized arteriosclerosis — indefinite
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) Md.

21. I certify that (I) (this hospital) attended the deceased from Jan 10 19[illegible] to Nov. 28 1960, that (I) (we) last saw the deceased alive on Nov 22 1960, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

22a. SIGNATURE Dr. E. Reese Wilkens M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 11/28/60
22c. PHYSICIAN'S NAME (Type) Dr. E. Reese Wilkens
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 11/30/60
23c. NAME OF CEMETERY OR CREMATORY London Park Cemetery
23d. LOCATION (City, town, or county) (State) Baltimore Md.

24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. ADDRESS Westminster, Md.
25a. REC'D BY REGISTRAR DATE DEC 2 '60
25b. REGISTRAR'S SIGNATURE Clarence E. Kroh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12466

CERTIFICATE OF DEATH

12444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

1 PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland — b. COUNTY: Carroll County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Westminster
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 1 Route 7, Westminster, Md. — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]
3 NAME OF DECEASED (Type or print): First: Howard Lee — Middle — Last: Sellers	4 DATE OF DEATH: Month: 11-1-60 — Day — Year: 1960
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 8. DATE OF BIRTH: 11-18-77 — 9. AGE (In years last birthday): 82 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer — 10b KIND OF BUSINESS OR INDUSTRY: ----- — 11. BIRTHPLACE (State or foreign country): Maryland — 12 CITIZEN OF WHAT COUNTRY?: U.S.A.	
13. FATHER'S NAME: Noyes Sellers — 14 MOTHER'S MAIDEN NAME: Amanda Zimmerman	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----- — 16. SOCIAL SECURITY NO.: 217-24-4163 — 17 INFORMANT: Springfield Hospital Records, Sykesville, Md. — Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive G.I. Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

578X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with cerebral arteriosclerosis, psychotic reaction. — 19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month — Day — Year: 19 — 20d INJURY OCCURRED While at work [ ] Not while at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from 7-15-60, 19--, to 11-1-60, 19--, that (I) (we) last saw the deceased alive on 10-31-60 19--, and that death occurred at 7:30 P.M. from the causes and on the date stated above

22a. SIGNATURE: J. Raymond Gladue M.D. — ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [ ] — 22b. DATE SIGNED: 11-1-60	
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.	22d. ADDRESS: Springfield Hospital, Sykesville, Md.
23a BURIAL, CREMATION REMOVAL (Specify): Burial — 23b DATE THEREOF: Nov 4/60 — 23c NAME OF CEMETERY OR CREMATORY: Wesley — 23d LOCATION (City, town, or county) (State): Sewell Co Md	
24 FUNERAL DIRECTOR'S SIGNATURE: Edward C. Tyson — ADDRESS: Hyattsville Md — 25a. REC'D BY REGISTRAR DATE: NOV 7 '60 — 25b. REGISTRAR'S SIGNATURE: Luther S. Evans	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12467

CERTIFICATE OF DEATH

12445

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead
c. LENGTH OF STAY IN 1b 10 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HORRELL Middle G Last SPENCER

4. DATE OF DEATH Month Nov Day 22 Year 1960

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Aug 25-1880

9. AGE (In years last birthday) 80 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Spencer

14. MOTHER'S MAIDEN NAME Jennie Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 213-24-7568

17. INFORMANT Address Mrs Robt Bunker - Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO (b) Arterio-Sclerosis — 10 y

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/31 19 59 to 11-22 1960, that (I) (we) last saw the deceased alive on Nov. 21 19 60, and that death occurred at 6a M, from the causes and on the date stated above

22a. SIGNATURE M. C. Porterfield M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) M. C. Porterfield

22d. ADDRESS Hampstead, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF Nov 25/60

23c. NAME OF CEMETERY OR CREMATORY Bethel Cem.

23d. LOCATION (City, town, or county) (State) Carroll Co Md

24. FUNERAL DIRECTOR'S SIGNATURE Edward S. Tipton ADDRESS Hampstead Md

25a. REC'D BY REGISTRAR DATE NOV 28 '60

25b. REGISTRAR'S SIGNATURE Arthur L. Hawes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12446

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 87 Years
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 56½ John St.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 56½ John St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIE — Middle FLORENCE — Last STEM

4. DATE OF DEATH: Month Nov. — Day 29 — Year 1960

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Aug 29 1872 — 9. AGE (In years last birthday): 88 yrs — IF UNDER 1 YEAR, IF UNDER 24 HRS: Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home-wife — 10b. KIND OF BUSINESS OR INDUSTRY: - — 11. BIRTHPLACE (State or foreign country): Westminster Md. U.S.A. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Columbus Engleman — 14. MOTHER'S MAIDEN NAME: Lallie Schweigart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Address 56½ John St. — Mr. Harvey W. Stem, Westminster Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Arterio Sclerosis & Hypertension — Several yrs
DUE TO (c): & Cardio Renal disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 15 1960, to Nov 29 1960, that (I) (we) last saw the deceased alive on Nov 26 1960, and that death occurred at 2.03 PM, from the causes and on the date stated above

22a. SIGNATURE: Wyleene Speiches M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 12/2/60 — 23c. NAME OF CEMETERY OR CREMATORY: Lonters Cemetery — 23d. LOCATION (City, town, or county) (State): Rural Mt Union Md

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster Md. — 25a. REC'D BY REGISTRAR DATE: DEC 2 '60 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12468

CERTIFICATE OF DEATH

Reg. Dist. No. 12447

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster
c. LENGTH OF STAY IN 1b: 70 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Westminster, Md. R. D. 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster
d. STREET ADDRESS Westminster, Md. R. D. 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Ellen — Middle Jane — Last Stonesifer
4. DATE OF DEATH: Month November — Day 25 — Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: December 2, 1880
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework, Retired
10b. KIND OF BUSINESS OR INDUSTRY: In her own home
11. BIRTHPLACE (State or foreign country): State of Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Stonesifer
14. MOTHER'S MAIDEN NAME: Barbra Ellen Sickle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
INFORMANT Address: John S. Stonesifer, Westminster, Md. R. D. 3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Kidney Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO (b): Arteriosclerotic Cardiovascular Disease — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia (Renal Insufficiency)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 4[illegible], to Nov 25, 19 60 that I last saw the deceased alive on Nov 25, 19 60, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W H Foard M.D. — ADDRESS (Street, city or town, state): Westminster, Md. — DATE SIGNED: 11-28-60
PHYSICIAN'S NAME (Type): W H Foard, M.D. — Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/28/60
22c. NAME OF CEMETERY OR CREMATORY: Bixlers E.U.B. Cemetery
22d. LOCATION (City, town, or county) (State): Nr. Westminster, Carroll Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard A. Little — ADDRESS: Littlestown, Pa.
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur E. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled out, it may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12469

CERTIFICATE OF DEATH

Reg. Dist. No. 12448

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: OLIVER Middle: Last: TRITE

4. DATE OF DEATH: Month: NOV. Day: 23 Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2 APR. 1893

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM LABORER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: PETER TRITE

14. MOTHER'S MAIDEN NAME: MARGARET BYERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): WORLD WAR I

16. SOCIAL SECURITY NO.: 215-14-1467

INFORMANT: RAYMOND McKINNEY Address: NEW WINDSOR, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

DUE TO

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Chronic myocarditis

DUE TO

(c) Pulmonary Chronic Bronchitis Bronchiectasis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 002X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-8- 1960 to 11-23- 1960 that I last saw the deceased alive on 11-23- 1960, and that death occurred at 6:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. N Legg M.D. ADDRESS (Street, city or town, state): Union Bridge Md. DATE SIGNED: 11-24-60

PHYSICIAN'S NAME (Type): T. H. LEGG M.D. UNION BRIDGE MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 26 Nov. 1960

22c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK CEM.

22d. LOCATION (City, town, or county) (State): CARROLL COUNTY MD.

23. FUNERAL DIRECTOR'S SIGNATURE: D. D. Hartle & Sons ADDRESS: NEW WINDSOR, MD

24a. REC'D BY REGISTRAR DATE: NOV 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur E. Krug

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12470

Reg. Dist. No. 12449

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LINEBORO
c. LENGTH OF STAY IN 1b: 30 YRS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LINEBORO
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY Middle H. Last WARNER

4. DATE OF DEATH: Month NOV. Day 15 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 5 1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CATTLE DEALER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CARROLL Co. MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J. FRANK WARNER

14. MOTHER'S MAIDEN NAME: MARY HOUCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-32-1542

17. INFORMANT: MRS HENRY H WARNER — Address: LINEBORO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min
420.1
DUE TO
(b): Coronary Arteriosclerosis — 4 yrs
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1953, to Nov 13, 1960, that I last saw the deceased alive on Nov 13, 1960, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W H Foard M.D. — ADDRESS (Street, city or town, state): Manchester, Md — DATE SIGNED: 11-17-60

PHYSICIAN'S NAME (Type): WH Foard MD. — Manchester Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11/19/60

22c. NAME OF CEMETERY OR CREMATORY: LINEBORO

22d. LOCATION (City, town, or county): LINEBORO (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: H Gaither — ADDRESS: Glen Rock Pa

24a. REC'D BY REGISTRAR — DATE: NOV 21 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55